

THE CONSTRUCTION OF SELF-HELP IN NORWEGIAN HEALTH POLICY

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ABSTRACT

The aim of this article is to scrutinize the underlying ideology and policy arguments that legitimize self-help as a new and important health promotion strategy in public health in Norway. The analysis is explorative, using public documents as primary data. The data consist of public regulations and guidelines, reports, green and white papers, and documents published by the Norwegian national self-help resource centre between 1998 and 2011. The data were collected in a step-wise procedure using intertextuality to establish relationships between the language and other elements of the text. The findings are related to three major themes: 1) making self-help an innovative health promotion strategy; 2) approving experienced-based knowledge as part of user involvement; and 3) from unskilled to modelling skills in the field of self-help. This analysis shows that self-help as a new health promotion strategy places more responsibility on individuals to make changes to improve their personal health conditions.

Key Words: self-help, Norway, discourse analysis, document analysis, ideology, welfare policy, health policy

INTRODUCTION

This article presents a critical analysis of constructing self-help as a new health-promoting strategy in Norway. In this context it is useful to distinguish between the terms self-help and self-help groups. Self-help concerns the way in which self-help is performed, while a self-help group is an arena where participants meet on a regular basis to solve a common problem. An increasing number of Norwegians struggle with long-term health problems or life difficulties, such as a divorce, loss of a family member, family-related abuse, violence, etc. Current health policy in Norway calls for better health promotion actions for these individuals and the inclusion of more user-experience and knowledge in health care (Ministry of Health, 1998a, p. 2, 2003). An important means to implement this policy in the area of mental health was the governmental Action Plan for Mental Health presented by the Ministry of Health in 2003 (p. 289) and adopted by Parliament as a 10-year program in the same year. One strategy for health promotion for people with mental health problems was to intensify the use of self-help and self-help groups. In the Action Plan for Mental Health it is argued that self-help embodies an new and alternative perspective and approach to health problems, since self-help focuses to a larger extent on the individual's health resources and his or her willingness to make life changes, rather than on the need for professional help. According to the health authorities this was in contrast to earlier strategies, which had focused more on health limitations or problems. Until the 21st century this perspective dominated health care debates on service and treatment providers in Norway (Ministry of Health, 2003).

The topic of self-help ties in with public health policy in Norway. Already in the 1960s and 1970s Norwegian health and welfare policy emphasised the principle of help-to-self-help and user involvement (Ministry of Health, 1998b). "Help-to-self-help" is an old principle in Norwegian Welfare State Policy, meaning that a person should support him or herself and manage everyday life as best they can, and that welfare measures should support such a policy (Adamsen, 2002; Kjørstad & Syse, 2001). "User involvement" means that those who are affected by a decision, or are users of services, should influence decision-making and the design of services. This definition has had strong traditions in Norwegian health policy since 1996 (Norwegian Parliament, 1996-1997).

Norway, with comprehensive provisions and public health care programs (Fosse, 2009), has over several decades called for co-operation with patient groups and organizations for their families and close relatives (Ministry of Health, 1998a). Nevertheless, the public authorities have never fully recognized or legitimized self-care and self-help as having equal status to the knowledge produced by professionals and experts in the public health care sector (Andreassen, 2005, 2009; Artman, Krogstie & Følstad, 2006; Bate & Robert, 2007; Rønning & Solheim, 1998).

Norway is considered to be what Esping-Andersen (1996) refers to as an advanced welfare state. Within this framework, illness and health and their management are conceptualized as something to be addressed not only as an issue for the doctor-patient, patient- or user organizations, but also as the subject of public policy generally and public health policy in particular. Most health care services and treatment are paid for through governmental funding and the wide range of health-care and welfare services must meet specific quality requirements and eligibility criteria to receive funding and be deemed legitimate. A guiding principle has been that services (such as a hospital) should be universally accessible with low or no payments for use, financed through a collective national social security scheme. The welfare state provides any citizen with comprehensive membership and employers and employees contribute according to a “pay-as-you-go” principle; i.e., progressive contributions based on income and receipt of services based on needs. The welfare state system endeavors to ensure that everyone, irrespective of personal finances and where they live, has access to good health care and care services of equal standard. At the same time, Norway has recently experienced an increased demands for public service and health issues. Many people seek help on the basis of disabilities or health issues, and this is not only due to a growing elderly population (Norwegian Directorate of Health, 2010b).

Norwegian health policy developments are related to a more egalitarian distribution of resources, and health relates to the nation’s economic distribution policy. The principle “health in all policies” is an example of Norwegian policy that includes provision for safeguarding the interests of health for everyone in society. At the same time, the health sector also demonstrates a greater degree of understanding for and recognition of the importance of other sectors in the promotion and distribution of health (Norwegian Directorate of Health, 2010b).

Current Norwegian health policy acknowledges the need for self-help care and self-help in shaping good health conditions in society (Norwegian Directorate of Health, 2004). The argument is that new groups struggling with health problems can benefit from self-help and self-help groups (Norwegian Directorate of Health, 2003, 2004). Public health authorities stimulate self-help initiatives based on the belief that participation in self-help and self-help groups will promote individuals’ independency and improve their ability to master problems themselves. Consequently, self-help can lead to less dependency on and help from care providers or professionals (Ministry of Health, 2003; Norwegian Directorate of Health, 2004). The health authorities also argue that self-help may improve life-quality and increase the opportunity of individuals to partake in their communities and society at large (Ministry of Health, 2003; Norwegian Directorate of Health, 2004).

Most of the intentions of this policy are realized through the Norwegian national self-help resource center (Nodal Point for Self-Help [NPSH]). This project was established in 2006 and is operated by the Norwegian Self-Help

Forum on behalf of the Ministry of Health. Its main purpose is to realize and implement the objectives of the National Plan for Self-Help (NPSH, 2009). After an evaluation of the NPSH in 2008, the project was prolonged (NPSH, 2010). Mainly the NPSH should seek to gather, systematize and disseminate knowledge of self-help that exists in Norway, and to bring attention to models for carrying out self-help, particularly in the field of mental health. One of its tasks is to build bridges between health care services, health authorities, volunteer organizations, politicians, and individuals to develop arenas for self-help activity and effective networks. Another important task is to collect and systemize experiences of self-help and to initiate research on relevant activities (NPSH, 2011a).

Today self-help is embedded in the National Plan for Self-Help and the work of the NPSH is organized as one national and four regional resource centers, all funded by the Norwegian Directorate of Health. The public sector is an important stakeholder in establishing self-help clearing houses in Norway, although these are sometimes established in a broader context of self-help and outside of the ordinary public sector.

AIM

The aim of this article is to scrutinize the underlying ideology and policy arguments that legitimize self-help as a new and important health promotion strategy in public health in Norway. Thus, the focus is on the construction of the meaning of self-help in health policy. The article examines the construction between symbols (terms related to self-help), the phenomenon (self-help as a state or occurrence) and reference points (experiences, associations, interpretations of self-help); called the triangle of meaning (Ogden & Richards, 1930).

UNDERSTANDING OF CONCEPTS

Understandings of self-help, self-care, and self-help groups vary in research (Borkman, 1999; Borkman & Munn-Giddings, 2008; Høgsbro, 1992; Karlsson, 2006; Nylund, 2000). One reason for the discrepancies over these terms has to do with the fact that different terms express the same idea. At the same time, identical terms can have different meanings. Yet another problem is how people understand themselves as they engage in self-help activities or join self-help groups (Borkman, 1999). When analyzing the construction of self-help in Norwegian health policy we recognize these terminological challenges and have defined the concepts in the following ways. The term self-care refers to an individual taking action to perform self-help, including care for oneself and taking responsibility for personal behavior. Some individuals will continue to feel victimized and disempowered when performing self-help, while others will feel the opposite. Both states are included when using the term self-care. The term

self-help refers to methods, skills, and strategies by which individuals direct their activities toward the achievement of self-help, including goal-setting, decision-making, self-evaluation, self-intervention, and self-development, etc. The term self-help group refers to the context of an organized setting that provides an environment for social interactions through group activities and mutual support for the purpose of self-help agency by means of self-help and self-care.

PERSPECTIVES

Studying an underlying ideology and policy arguments can be accomplished according to different perspectives. Rather than analyzing the ideology and policy-making per se, this study focuses on how a certain ideology and arguments are formed and expressed as meanings about self-help. This is done using a Foucaultian (Foucault, 1991) perspective, arguing that governments, through public policy, strive to “produce” citizens that are best suited to fulfill those policies and conform to the organized practices (mentalities, rationalities, and techniques) through which subjects are governed. Consequently, governmentality refers to “how” policy is governed; that is, the calculated means of directing how we behave and act (Jeffreys & Sigley, 2009). According to Foucault, this is carried out by establishing a mentality of rule or a relatively systematic way of thinking.

The mentality of rule delineates a discursive field in which the exercise of power becomes “rationalized” (Lemke, 2001, p. 190). This is particularly dominant in late modernity, when governments cannot use external exercises of power to force citizens to act in accordance with the government’s goals. Rather, individuals must themselves embrace and act upon these goals as both free and responsible citizens (Rose, 1999). Thus, government will work to create a social reality that proposes that “free and responsible citizens” already exist.

In late modern neo-liberal government this is achieved through attempts to link a reduction in state welfare services and security systems to this social reality. A government can then begin to govern its citizens, not through intrusive state bureaucracies backed by legal powers, or the imposition of moral standards under a “religious” mandate, but by establishing conditions in which autonomous individuals govern themselves through their freedom. By transforming citizens as subjects with duties and obligations, and constructing them as individuals with rights and freedoms, modern individuals are not merely “free to choose” but obliged to be free, “to understand and enact their lives in terms of choice” (Rose, 1999, p. 87).

This freedom differs from earlier forms of freedom. It is the freedom to realize our potential and our dreams by reshaping the way in which we conduct our lives. Through our freedom, particular self-governing capabilities can be acquired in order to bring our own ways of conducting and evaluating ourselves into alignment with political objectives (Rose, 1999, p. 155). Self-help can be seen as a type of self-governing capability. However, the term self-help is complex.

Within the discourse, the meaning of the term and what it is said to be and represent vary (Borkman, 1999; Høgsbro, 1992; Karlsson, 2006). Self-help can be approached, as suggested by Karlsson (2006, p. 6), as an outcome of late-modern society, a society that contains new and more flexible coherences. Traditional values are questioned and greater emphasis is placed on individual choices.

Thus, a change in perspective on human agency is taking place; the individual is now more a consumer than a producer. Family ties and relatives are becoming less important. Instead individuals connect more loosely with voluntary networks and groups when addressing problems (Karlsson, 2006, p. 6). Self-help and self-help groups may fill a certain function in these types of society, e.g., in self-help groups you can change groups if you are not satisfied with the one you are in. Accordingly, they can be seen as a form of modern agency, a place where one can find individuals struggling with the same issues as oneself, and use the experiences of peers in self-help groups to find ways to deal with self-governing capabilities. Another aspect that promotes self-help as a health strategy in modern society relates to the fact that self-help and self-help groups are embraced by conservative as well as radical political parties (Karlsson, 2006; Trädgårdh, 1999).

The formation process underlying specific self-help groups relates to the willingness of the individuals to share experience and knowledge about the same predicament, disease, or disability. Self-help groups are usually informative, egalitarian, and supportive of the participants attending the groups (Borkman, 1999). The broader context of self-help groups can be referred to as the “third sector” or the voluntary action and non-profit sector (Borkman, 1999, p. 17). This sector is important for the work of health promotion, particularly in Scandinavian countries. The concept of health promotion is mainly used when the intention is to promote health in a “positive” sense. That is, when health is based on a subjective experience of health and not disease, thus defining health promotion on the basis of measures that can be implemented to promote individuals’ health (Downie, Fyfe, & Tannahill, 1990; Medin & Alexanderson, 2000; Naidoo & Wills, 1994). Accordingly, public health policy relates health promotion to the process of enabling people to increase control over, and to improve, their health. In other words, to reach a state of complete physical, mental and social well-being, an individual or group must be able to identify and to realize aspirations, to satisfy needs, and to change or cope with the environment, according to the World Health Organization (WHO, 1986). Those who advocate self-help place more responsibility on the individual to realize processes of increased control and health improvements.

SOURCES AND METHOD

This study is based on a qualitative explorative study design using documentary sources. Through documentary analysis (Scott, 1990) it is possible to search systematically for meaning-making of the phenomenon, symbols, and reference points associated with self-help and self-help groups. In this study, we searched

for meaning-making in virtual or written documents using the keywords “self-help,” “self-care,” “health promotion,” and “health care” or combinations of these keywords. This gave a data set consisting of approximately 1000 public regulations and guidelines, reports, Green and White Papers, documents from the NPSH, and other public documents (including pamphlets and digitalized political debates), published between the years 1998 and 2011. These data were analyzed for their relevance to the aim of this study. Relevant texts were analyzed for their formal and informal genres or expressions of discursive practices for what self-help should be or be practiced as, and also included analysis of dialogue and political story-telling. The analyzed data are addressed as positions or points of view (Patton, 2002), not only as “written” or “oral” scripts that are written or spoken spontaneously. Instead, these documents and utterances are approached as a language of social-institutional practice (Fairclough, 1995); i.e., a practice that reflects a certain ideology, knowledge or fundament upon which to present “facts” about a phenomenon (Hedlund, 2004). The documentary analysis was conducted to achieve an understanding of the contextual framing of “self-help” when this phenomenon is present in health policy in Norway. The purpose of this is to gain a deeper understanding of the underlying ideology and policy arguments that legitimize the meaning-making of self-help as a new and important health promotion strategy. The data were collected in a step-wise procedure. The first data set consisted of a total of 1456 documents, discovered through searching for key words in public web sources such as *government.no* (information from the Government and the Ministries) and *stortinget.no* (information from Parliament) and *Norway.no* (gateway to information about the public sector in Norway) and *selvhjelp.no* (NPSH). The second data set consisted of (verbal, virtual, or written) documents that were intertextually related to texts and documents in the first data set. In this study, intertextuality (Fairclough, 2003) was established when a relationship between the language and other elements of the text from the first data set could be linked to other data. For instance, when a reference was made to another text or statement that was external to the first data set, it was collected and included in the second data set and then analyzed.

The data set was analyzed through multiple readings to identify forms of interpretive frames of reference embedded in the meanings of self-help and health promotion when this is presented in Governmental policies (Prichard, 2005). To gather knowledge about the research question we analyzed the interpretive and political strategies expressed in the documents and critically examined the documents for the particular target groups they addressed and how they referred to other types of documents and information sources and websites. We re-read different forms of data to explore these issues. The interpretive analysis addressed the mentality of rule delineated from the discursive field in which the exercise of power over the meaning and contextual framing of self-help in health policy took place. To establish a discursive field and contextually frame self-help in health policy, specific actors (organizations, networks,

and individuals) exercise power over the definitions and content of self-help. The meanings attached to self-help appear to reflect and recreate a discourse of rule abstracted from such actors and their activities. How this is executed and by which actors and organizations is described in more detail in the following analysis of our findings.

FINDINGS

Three major themes emerged from the data analysis as relevant to answering the aim of this article. These were:

1. making self-help an innovative health promotion strategy;
2. approving experienced-based knowledge as part of user involvement; and
3. from unskilled to modeling skills in the field of self-help.

These themes evolved as patterns of overlapping elements and distinctiveness regarding the underlying ideology, the policy arguments that legitimized self-help as a new and important health promotion strategy in public health in Norway.

1. Making Self-Help an Innovative Health Promotion Strategy

One finding related to the development of a new health promoting strategy. Self-help is presented as an answer to new challenges and demands in health promotion. The government and health promotion policy started to focus more on programs in favor of citizenship, consumer identities, and an individual health problem approach (Norwegian Directorate of Health, 2009). Thus self-help and self-help groups are, on the one hand, presented to legitimize a new means of emphasizing such a focus. The argument is that self-help may make people more aware of “self-therapy” or “group-therapy” as measures for developing experiential knowledge. People with similar health problems or life difficulties may develop their own strategies to deal with the problem and thus the demands on an already over-taxed health care service may be reduced. It is argued that self-help as a strategy can be created (and indeed is preferred to be created) as a complementary or alternative strategy to professional health promotion (Dørum, 2007; Norwegian Directorate of Health, 2003, 2004). Consequently, long-lasting problems related to physical or mental health lifestyles, etc. are conditions that benefit from self-care and self-help arrangements, according to the health authorities (Norwegian Directorate of Health, 2004). Self-management and self-help are recognized as “good medicine” or a means by which people adapt their behavior and make “healthy choices” (Rogers, Bury, & Kennedy, 2009). However, the definition, understanding, and methods for self-help and self-help groups vary in public policy. Below we demonstrate how this variation is dealt with by the Norwegian health authorities.

By 1998, the Norwegian government and health authorities in a White Paper (Ministry of Health, 1998a) welcomed and approved the need for new means, particularly from grassroots or alternative movements, to address health promotion programs. One main message that was emphasized in this paper was that public health policy should pay more attention to and benefit from “self-to-self-help” enterprises, such as the Norwegian Anxiety Ring, the Norwegian Self-Help Forum, the work of peers in user and patient organizations and so forth, which were known to exist outside the public health care sector. In the paper, it is claimed that public health care is over-influenced by a modern epidemiology that has focused on easily measurable biological variables at the expense of the large and important issues in public health (Ministry of Health, 1998a). This White Paper argues that public health policy needs to be changed to include and be adapted to health promotion activities found in the third sector, focusing on the empowerment of individuals to support them in making lifestyle changes. The paper underscores the need for using self-help, such as the work of the Norwegian Anxiety Ring. The Ring, which receives grants from the Norwegian Directorate of Health, has existed since 1986, and the empowerment concept is a cornerstone in the work of this network organization. It is a foundation that aims to spread experience-based knowledge about anxiety and self-help founded in a human holistic perspective. It is keen to show that the experience of anxiety can be used as a driving force of change in the individual’s life. In the Green Paper “Find a use for everyone—enforcing public health in municipalities” (Ministry of Health, 1998b), the proceedings of the Norwegian Self-Help Forum follow-up to the Norwegian Anxiety Ring is given attention. The Forum was established in 1998 and aims to be a national competence and resource center for the development and use of self-help. In the public paper, the Forum’s content and definition of self-help became interesting for Norwegian authorities. According to the Forum, self-help meant:

Self-help is to get hold of one’s own possibilities, discover one’s own resources, assume responsibility for one’s own life and steer it in a desired direction. Self-help is to set in motion a process of moving from passive recipient to active participant in one’s own life. (Ministry of Health, 1998b, p. 289)

In the main body of the paper an individual approach to health problems and life difficulties is appraised as an empowerment ideology. By recapturing personal resources through self-help means, it is argued that society will benefit, as self-help makes individuals strong and safe (Ministry of Health, 1998b). Here we see that public health authorities are outsourcing to the third sector what was formally an important part of official health policy. Organizing self-help should be done with partners outside the government sector; it stresses in its document the value of a transition to an individualized health promotion policy, in which the third sector should take greater responsibility for developing

measures such as self-help to improve public health. The same ideology of self-help strategies is followed up in several public reports during the following decade (Ministry of Children and Equality, 2005; Ministry of Culture and Church, 2007; Ministry of Education and Research, 2004; Ministry of Health, 2003; Ministry of Justice and the Police, 2004, 2006, 2007; Ministry of Local Government and Regional Development, 2004).

By 2004, public policy increasingly stresses the use of lay perspectives and lay knowledge in public policy. In 2004 the authorities campaigned for and allied themselves in a partnership project with the NPSH to expand knowledge about self-help, methods, and strategies. The project was organised and run by the NPSH and funded by The Directorate of Health. The latter is a specialist directorate and an administrative body under the Ministry of Health and the Ministry of Labour and Social Inclusion. The main objective was to ensure that the “National Plan for Self-help” was put into action (Norwegian Directorate of Health, 2004). This plan was an outcome of discussions between the Directorate of Health and the NPSH. The National Plan for Self-Help had its background in the Governmental Action Plan for Mental Health for 1999-2008. The initiative for making a public plan for self-help came from ideas presented in this plan. One purpose was to reform and improve services and care for the growing number of people in Norway suffering from mental problems or illnesses. In the plan, the Directorate of Health stresses the importance of finding new strategies to be able to help “everyone” that needs help. Based on no empirical evidence, research or publications, they point to a future scenario in 2010 when about “half of the Norwegian population would develop ailments and diseases during their lifetime” (Norwegian Directorate of Health, 2010a). Just a few years earlier, in a public statement on psychiatry (Hol, 2006), the same authorities stressed the need to address a number of deficiencies in the mental health care services, which should be accessible at all stages of the processing chain of treatment to be able to meet future demands for health services. The Governmental Action Plan proclaimed a need to develop new means and thereby provide quality of services by unifying and creating coherent treatment networks that operated across sectors and administrative levels. Self-help became such a new means and a supplement to mental health care (Hagen, 2003). The National Plan listed these self-help initiatives that should be taken and supported by grants from public health authorities:

1. to establish a nodal point to carry out extensive information and dissemination work, to develop knowledge and to act as a coordinator in a self-help network;
2. provide funds for research and knowledge development;
3. establish a grant scheme to stimulate increased activity in relation to mental health; and
4. organize international and national conferences with the intention to gather partners in the field and establish a network.

As self-help became an innovative health promotion strategy, user involvement and the incorporation of experience-based knowledge of health problems became valued as ends in themselves in health policy, as well as for their ability to promote other objectives, such as: to fill gaps between supply and demand of health care services, and to increase the quality of services by incorporating experience-based knowledge into the services. In addition, user-led knowledge and experience-based knowledge were legitimized by giving authority and funding to networks organized in the third sector to spread information about experience-based knowledge.

2. Approving Experienced-Based Knowledge as Part of User Involvement

Another pattern in the analyzed data dealt with how to approach experience-based knowledge as a part of user involvement, which was now crucial in planning a new innovative health promotion strategy. One clear expression of the need for incorporating the experience of users to construct a better health care service is found in an interpellation in the Norwegian Parliament when representatives debated the implementation of the “National Plan for Self-Help” (Norwegian Directorate of Health, 2004). This happened when a representative, Odd Einar Dørum of the Liberal Party, held an interpellation before the then Labor Minister of Healthcare Sylvia Brustad (Dørum, 2007) during Ministers’ Question Time. Dørum praised the government for adopting the national plan and argued that its implementation would improve mental resources for the entire population of Norway. Further, he argued that by calling attention to self-help in public health, the health authorities recognized knowledge possessed by users of health care services and their experience of living and dealing with a problem. The power of civil society was thereby brought into public health promotion programs for the first time, according to Dørum (2007).

In the analyzed data it is evident that the parliamentarian supported the ideology behind the National Plan for Self-Help, which he argued would make visible the important work of legitimizing experiential knowledge in health-promoting strategies (Norwegian Parliament, 2007). Moreover, he claimed that self-help would benefit the entire public health sector, as it works as a supplement to professional help:

Dørum: If we bring self-help into our encounter with the Norwegian health reality, we can see that self-help contributes to the development of new knowledge in the encounter between experience-based and professional knowledge. It quite simply gives those resources we have a chance, in addition to all the professional knowledge that a health-oriented help apparatus possesses. I have collected some comments from people who have lived with self-help. One of them says: To speak with someone who has knowledge of the same thing as oneself, is recognition and creates meaning.

Another says: To meet other people who are in a situation that is almost the same as your own comes close to something magical. Or: It suddenly explains the strange impulses you come up against in a person when he or she incorporates this recognition in their life. (Dørum, 2007, p. 2)

In the data we see that it is unclear when the National Plan for Self-Help was to be implemented. However, we see that in 2006 public web pages for the NPSH were made available and that this project linked to previous webpages from the Norwegian Self-Help Forum (2011). The Norwegian Directorate of Health gave the Foundation “Norwegian Self-Help Forum” the task of preparing a draft plan to strengthen the self-help effort and implement the Self-help plan. This provided a backdrop for forming the NPSH in April 2006 on behalf of the Norwegian Directorate of Health. Additionally, the analysis demonstrates that the NPSH is strongly connected to the ideology of The Norwegian Self-help Forum.

The analysis shows that the implementation of the National Plan for Self-Help included an aim to expand knowledge of self-help and to distribute this knowledge to the existing self-help groups and networks (Norwegian Directorate of Health, 2004; NPSH, 2011b). A website (selvhjelp.no) with information about the implementation of the plan was made accessible in 2006. Here self-help is presented as a tool and method for attaining mastery, to gain the ability to change, and to increase quality of life for everyone. We see that knowledge of personal change and the experience of change in quality-of-life are important dimensions in self-help, implying that experience-based knowledge is a key element. Ownership of problems and willingness and self-coping [referred to as mastery in their own English version of the webpage] are also mentioned as crucial aspects. Thus, self-help is constructed as an important method for mobilizing human resources and as a tool to enable people to take responsibility for their own problems: it is aligned with self-efficacy and user involvement. The self-help effort represents initiatives that are aimed at strengthening the ability and opportunity of individuals to partake in their own process of change (NPSH, 2011b).

We see in the analyzed material that self-help is linked to user involvement and to a personalized approach to the process of change. With this, the applied field of self-mastery is no longer limited to mental health per se, but has become a more universal tool for working with life’s difficulties. It is argued that self-help is a matter of mental approach, a willingness to make changes and as such can be used to address any problem in life.

Self-help is both an understanding and a tool for all people with an existing or potential life problem. In this way the self is both preventive and rehabilitative, whether you have a diagnosis or not. Understanding self-help is also a tool in the meeting between people (NPSH, 2011b).

This means that people are not only users of health-care services when they have problems. They also possess knowledge which may contain the potential for personal mastery over these problems through self-help. The quotation above

reflects the elements of self-help and points out what is important when using this as a method for mastering life difficulties.

A document from the NPSH that addresses user involvement states that the NPSH approaches self-help along the same lines as in Norwegian public policy documents (Norwegian Parliament, 1996-97; NPSH, 2011b). In the documentation, legitimacy is given to the notion that those affected by a decision, or users of services, should also influence decision-making in relation to health-care services (Norwegian Parliament, 1996-97; NPSH, 2011b). Further, the NPSH stresses that user involvement must be contextualized, i.e. users are not users per definition; they are indirectly connected to the use of a service or a system (NPSH, 2011a). In this statement, and other texts referring to this statement, the significance of this is unclear, i.e., what is required for the users to become connected to the use of a service or a system.

In public documents a distinction is made between user involvement at a system level and on an individual level (Norwegian Parliament, 1996-97). In the documents from the NPSH, a self-help approach is presented as involving both levels. On the individual level, self-help can be used as a tool for strengthening oneself and participating in personal rehabilitation or treatment processes. On the system level, the health-care sector needs to be open to knowledge from users in order to improve the quality of health care services.

The data analysis demonstrates that the use of self-help groups and self-help is linked to concepts such as empowerment and user involvement, which in turn reinforces the meaning of self-help. The NPSH documents underscore the need for more emphasis on user involvement in order to renew the Norwegian health care system (Hagen, 2003; Norwegian Directorate of Health, 2009; Thoresen, Nytingnes, Ørstavik, Paulsen, & Council for Mental Health, 2004; Wiig, Aksnes, & Brofoss, 2009).

The NPSH documents also argue that self-help is an important tool for health professionals:

Health professionals meet daily challenges not just in relation to users' needs, illnesses, pain or treatment. An important part of working with people takes place in the relational space between the user and the helper. (NPSH, 2011c)

In the space between the helper and the user, self-help can be a tool that supports the empowerment of the user. User participation in practice requires an expanded knowledge among health care personnel, which can first come into play when the helper combines an emotional understanding of the situation with cognitive reflection and creative communication skills, according to recommendations from the NPSH (2011e). It also argues that experienced-based knowledge becomes embedded in user involvement when helpers and users collaborate closely:

Knowledge production can be regarded as a circular process. It is in the meeting between people, in the cooperation between helper and user, and between helpers and helpers, that this knowledge grows. In this relationship,

new knowledge may evolve. Helpers must be trained in creating spaces for such encounters, and all involved parties must learn to use such spaces. (NPSH, 2011e)

Here a focus emerges on how health professionals need to develop new skills in acquiring and disseminating knowledge based on experiences of people seeking help from professionals. The NPSH argues that this can make an important contribution to developing good practice in health-care and helpers' and users' relationships.

As noted in our introduction, Norway has well-developed national welfare measures and support schemes. However, there are still a number of weaknesses with regard to possibilities for users to exert influence and participate. User participation is an approach that guarantees quality assurance in the design of services and plans through the transfer of direct experience-based knowledge to decision makers and providers of services. Taking the users' needs, wishes, and experiences into consideration and using this experience to develop a good relationship between users and helpers, health care providers and services constructs the possibility to develop new knowledge in health care. To fulfill this aim, self-help is considered particularly important. However, the NPSH policy arguments are unclear as to whether the democratization of health care services is the ultimate policy goal. In the documentation, the development of democracy and the legitimacy of self-help as an important new health promotion strategy are frequently mentioned. It is also possible to trace an argument for health care professionals and users needing to develop certain skills and possess specific competencies in order to make use of experience-based knowledge as a tool for user involvement. Thus, self-help is not something that just anyone can engage in.

The new policy construction approving experienced-based knowledge as a part of user involvement includes a greater emphasis upon the need to give a voice to users' perceptions of problems and their experiences in solving them, arguing that it is important to develop new strategies for user involvement in public health policy.

3. From Unskilled to Modeling Skills in the Field of Self-Help

The third pattern found in the analyzed data relates to how to model skills and knowledge of self-help when constructing a new health policy. This modeling refers to an ideology that consists of a set of beliefs upon which people base their actions, in this case the special belief that self-help is something from which people with problems can draw positive energy and help. It includes a gradual modeling of self-help by which a person becomes skilled at doing self-help and develops a great deal of knowledge about this particular subject.

When the NPSH for Self-Help was established in 2006, self-help was defined as “a method whereby individuals have the potential and possibility to use inner resources to strengthen their ability to manage their own lives and increase their own quality-of-life independent of professional assistance” (NPSH, 2011b). There was no clear preference for which model to use to achieve a method to allow individuals to realize their potential to manage their lives independent of professional assistance. However, the method of self-help was in accordance with the understanding that is used by the Anxiety Ring in the mid-1980s and public documents from the Ministry of Health and Social Affairs in 1998; in the Green Paper “Find a use for everyone— enforcing public health in municipalities” (Ministry of Health, 1998b). How to “do” self-help and use particular methods is not clear when the Norwegian health authorities in 2004 suggest the need for a national plan. The National Plan for Self-Help does not provide guiding principles for any particular preference or appropriate method to motivate people to use self-help (Norwegian Directorate of Health, 2004). Instead it stresses that self-help as a method should be accessible to anyone in need of making personal changes, regardless of life difficulty or health problem. The National Plan recommends that the person must engage him or herself in a process that improves their ability to identify and articulate problems and thereby create a basis for improving life to be able to benefit from self-help methods. It emphasizes that self-help methods make it possible to mobilize internal force, will and energy and thereby be empowered:

Self-help is built on the principle of mutual help and the work is based on the participants’ own experience and knowledge. It is a method that motivates individuals to use their own resources to enable them to handle the stresses they meet. It is a process that can better enable individuals to identify and articulate their problems and thereby create a basis for improving their own life situation. This mobilization of individuals’ own power is known internationally as “empowerment.” (Norwegian Directorate of Health, 2004)

Later, the same plan clearly states that there is no preference as to model and the plan demonstrates openness toward various ways of organizing self-help:

In the continuous effort to strengthen the field of self-help it must be respected that some self-help organizations want to differentiate between various methods of running self-help groups. (Norwegian Directorate of Health, 2004)

Modeling self-help is instead focused on implementation issues. After 2006 the NPSH continued its work to implement the National Plan for Self-Help for various target groups and networks inside and outside the public health care sector by gathering, systematizing, and disseminating more knowledge about self-help. It started courses for those who initiate self-help groups; providing updates on the website, producing reports, distributing pamphlets, participating in public meetings and inviting people to particular meetings and education

programs on self-help. One of the main focuses was to contribute to modeling self-help and specifying the ingredients necessary to develop self-help as a method. Already in 2006 the NPSH started to disseminate new activities and create synergy effects across different environments that until then focused on self-help activities. For instance, patient organizations, relative organizations, church organizations, volunteer centers, and local self-help entrepreneurs were linked together in the network that the NPSH was shaping. Website orientations and clearing houses for self-help in different cities developed a new type of arena for sharing knowledge and insights. In the analysed data we found no trace of attempts by the health authorities to enforce a specific method or tools for doing self-help, leaving this issue to the NPSH to clarify, specify, and decide upon. The NPSH emphasize that their work is commissioned by the public health authorities in Norway. From 2009 the NPSH stresses their close collaboration with these authorities:

From 2009, a grant for the operation of the NPSH is included in the national budget. The work continues to be managed on behalf of and in collaboration with the Norwegian Directorate of Health. (NPSH, 2011d)

In the documentation it is also argued that the Norwegian health authorities are at the forefront of implementing a public policy that includes self-help as a one element in an attempt to renew public health policy, involving partners from the voluntary sector (Norwegian Directorate of Health, 2004).

In the analyzed data we find that part of the construction of the meaning of self-help in health policy has a European influence. The NPSH for Self-Help regularly exchanges knowledge with other European “friends” and partners in the area of self-help. Staff attended the “European Expert Meeting for Self-Help” (EEExM) in Berlin in 2009. We here see a turning point in the NPSH’s presentation of self-help in a narrower sense than previously used (NPSH, 2009). It no longer adopts a general and open approach to how self-help can be organized. Indeed the NPSH stated in Berlin in 2009 that their understanding of self-help groups departs somewhat from “peer work” and “self-help related activities” in Norway. These types of groups are mostly led by a person who has the same kind of problem as the participants of the group (NPSH, 2009). In contrast, the type of self-help groups that the NPSH argues it will initiate, underscores how important it is that leadership rotates among the group participants and that an initiator should only assist the group initially and then withdraw from the group. The NPSH gives an account of self-help as a way of thinking, or what they call “a specific kind of self-understanding.”

The Internet plays an important role in this work and in constructing advocacy groups that push for changes to be made in the health-care sector, as emphasized below:

One of the most important tasks for the NPSH is to ensure that information about self-help opportunities is made available to the population

in general. This would require that we succeed in making self-help more visible through both traditional and digital media expert meeting in Berlin. (NPSH, 2009, p. 5)

The NPSH communicates a situation in which users or patients struggling with health problems are more engaged in health policy. Its arguments are similar to what Hobson-West (2007) found to be true in the United Kingdom, where patient education programs had renewed British health policy. According to the NPSH, they are part of a new type of movement that will bring in new points of view and reform Norwegian society. People become citizens through the initiatives they engage in as self-helpers or people who promote self-help. They are no longer just a “patient” or “user.” Instead, through participation in self-help groups, people have the opportunity to become active citizens and change their environment through the power and force of their own personal resources. The NPSH also supports the establishment of clearinghouses and self-help groups in the municipalities and regions to not only organize and distribute information and knowledge about self-help, but serve as a space for sharing experiential knowledge. Even if these groups are autonomous, the NPSH for Self-help finds it important to highlight knowledge and construct a framework for the meeting places for self-help groups.

The data analysis shows that self-help knowledge was initially introduced and legitimized as “lay knowledge” from what can be referred to as an “informal health care sector” (Nettleton, 2006). This strengthens the status of patients or users, and includes lay health beliefs and the knowledge they produce. In the documents from the NPSH, knowledge does not exclusively refer to patients or users of health care services. Instead, lay knowledge refers more broadly to human and personal aspects of experiencing a life difficulty or chronic health problem that does not necessarily require professional or expertise knowledge. The analysis shows that the lay perspective on health care that is promoted by the NPSH seeks to establish new agendas and terminologies around self-help and to make this applicable to any life-problem regardless of whether it results in a disease or an illness. Thus, by 2009, a shift of focus in the Norwegian approach to self-help appears (NPSH, 2009). This document shows that attention is shifting to expanding the objects to be encompassed by self-help and to transform it into a “universal” tool for human change.

The promotion of self-help policy that the NPSH now advocates demonstrates a shift from patient rights to individual responsibility for dealing with and managing burdensome lives and difficulties. This indicates that the meaning of self-help is also taking on new content: health professionals no longer have sufficient skills due to a lack of insight into the health problems that users and patients are struggling with. According to the analyzed data, the NPSH argues that health care personnel must be trained in complementary skills and self-help arrangements in order to deliver better health outcomes in the population:

To trade relational skills in their [professional] daily practical work requires different skills for helpers than those he or she has learned through a degree program. The most important challenge facing helpers is to endure the user's situation, the user's pain. This challenge is often more painful than many helpers are prepared for. To deal with this pain, the helper must dare to experience how this challenge is met, and thoroughly the helper must be aware of the pain and strengths, and the extent to which the helper knows what it takes to be able to utilize own resources. (NPSH, 2011e)

In the analyzed data about the construction of unskilled to modeling particular skills in self-help, we see that the NPSH is tasked with both defining content and understanding how one should work with self-help as a model. Initially, the definition of self-help and the methods for enacting it are fairly open, but in due time the approach changes. Thus, the importance of self-help is argued to be part of preventive care and health promotion programs and the promotion of an "idealized self-helped individual" that is empowered, autonomous, "expert on one's own problem," active in improving one's own life and life conditions. Self-help has become more strongly linked to a specific method. After 2009 self-help competence constitutes a particular skill set, and becomes the responsibility of those with specific skills in the field.

DISCUSSION

The analysis shows that the underlying ideology and policy arguments are used when self-help is legitimized as a new health promotion strategy in Norwegian public health policy. Various constructions of meanings are assigned to self-help and to self-help groups in recent policy. The ideology of self-help is linked to both previous and current principles in public policy and the Norwegian welfare state, and to ideologically-based future hopes for managing health in the population. The analysis also reveals that the ideology of users' knowledge and experience-based knowledge become important elements in this construction process and that people with long-term life difficulties or health problems are approached as active citizens. A basic methodological principle for self-help is that the method contributes to the person/user developing an awareness of his or her situation, which helps the individual to identify what needs to be changed in order to engage again with life and deal with problems. However, to be able to develop this technique, specific knowledge in self-help is required and people need to be trained.

The argument put forward for self-help as a new health promotion strategy introduces a "consumer voice" or incorporates "consumer movements." It strives to "produce" citizens that are best suited to fulfill the policies of the government and conform to an organized practice (mentalities, rationalities, and techniques) of becoming "consumers" (Foucault, 1991). It has links to a different type of "sick role" than that originally formulated by Parson (1975), who claims there

exists an in-built imbalance between expert judgment (that of professionals) and patient judgment. Patient judgments relate to labels such as “patient” or even “users.” Patients’ and users’ knowledge is mixed with meanings created by professionals. When patients or users respond to medical and professional knowledge about a health-related problem, they respond on the basis of both the professional knowledge about the problem and their own experiential knowledge. The work and ideology of the NPSH argues along the same lines as Illich’s (1976) original critique of modern medicine, who claims that health care creates itself as its own nemesis because it only allows professional knowledge to enter the treatment arena, rejecting the experience and knowledge of patients. Thus health care appears to be unresponsive to changing social and economic circumstances to improve “patient problems.” Ultimately this can lead to allowing only organized “consumer movements” into the health care sector. Patients’ experiences must be “converted” into consumer knowledge in order to play a role in changing the health care sector. However, patient organizations and grassroots movements do not want changes in the health care sector that are based solely on ideas of consumerism. Rather, they desire change based on the recognition of patients and their knowledge (Haug, 1973; Starr, 1982). In the data analyzed the same line of critique is used to change the medical or economic discourse in the health care sector. An arena is necessary within which patient or user knowledge can develop.

CONCLUSION

This analysis shows that the construction of self-help as a new health promotion strategy places more responsibility on the individual to make changes to improve personal health conditions. Using self-help as its means, the new health promotion program achieves “subjectivising” of problems (Focault, 1991). Those engaged in self-help internalize the values embedded in this notion and apply them as truths about what it means to be a competent community member and user of self-help. In the Norwegian context, a professionalization of self-help has entered the field of health promotion, with the Norwegian national self-help resource center being given a key role in defining this professionalization process.

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